Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING B. WING	<u></u>	С			
NV\$3224MDX		NVS3224MDX				03/16/2011			
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA					
LAS VEGA	AS RECOVERY CENTER			71 N BUFFALO DRIVE S VEGAS, NV 89129					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE			
М 00	INITIAL COMMENTS	S		M 00					
M 136 SS=E	The findings and con by the Health Division prohibiting any crimin actions, or other clair available to any party state, or local laws.  The state licensure s 3/16/11, in accordance Facilities for Modified effective 1/1/2000.  The facility is licensed medical detoxification were reviewed, ten e  The following deficient  NAC 449.15345 Hea  9. Each client of a fact after admission, under skin test. If the client of a two-step Mantou has not had a single within the 12 months facility, the client shad Mantoux tuberculin s  This Regulation is not Based on record revifailed to ensure 3 of a tuberculosis testing (	clusions of any investigations of any investigations of any investigations of all or civil investigations are for relief that may be a under applicable feder urvey was conducted on the control of the c	d as s, s, seral, nn, story and a story a story and a story a story and a story a story and a story a story a story and a story a	M 136					
	the employees had evidence of a two-step TB test and annual TB tests, however the annual tests were done one month late).  Severity: 2 Scope: 2								
			1 111 10 1		f this statement of deficiencies				

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		, ,	LE CONSTRUCTION	(X3) DATE SUF COMPLET			
		NVS3224MDX		A. BUILDING B. WING		C <b>03/16/2011</b>			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		-		
LAS VEGA	AS RECOVERY CENTER			3371 N BUFFALO DRIVE LAS VEGAS, NV 89129					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
M 171	Continued From page	2 1		M 171					
M 171 SS=C	NAC 449.15351 Dieta	ary Services		M 171					
	2. Menus must be planned and followed to meet the nutritional needs of the clients in accordance with the recommended dietary allowances recommended by the Food and Nutrition Board of the National Research Council, National Academy of Sciences.								
	Academy of Sciences.  This Regulation is not met as evidenced by: Based on record review on 3/16/11, the facility failed to ensure menus were planned and reviewed by a registered dietician.								
	Severity: 1 Scope:	3							
M 173 SS=C	NAC 449.15351 Dieta	ary Services		M 173					
	4. Menus must be in writing, planned in advadated and posted and kept on file at the faciliat least 90 days. Any substitution must be no on the written menu so that the menu on file reflects what was actually served.		ity for						
	Based on observation interview on 3/16/11, the menu was posted	ot met as evidenced by: n, record review and the facility failed to ens , kept on file for 90 day e documented on the m	ure s,						
	Severity: 1 Scope:	3							
M 174 SS=F	5. Adequate facilities preparation, serving, food must be provided	and equipment for the refrigeration and storagd and must meet the		M 174					
		te board of health, inclu regulations set forth in	iding,						

Bureau of Health Care Quality and Compliance

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
			C 03/16/2011					
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE		10/2011	
	AS RECOVERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3371 N BUFFALO DRIVE  LAS VEGAS, NV 89129					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
	<ul> <li>174 Continued From page 2 chapter 446 of NAC.</li> <li>This Regulation is not met as evidenced by: Based on observation, interview and record review on 3/16/11, the facility failed to ensure the kitchen complied with the standards of NAC 446.</li> <li>Findings include: <ol> <li>Critical Violations:</li> <li>There were two badly dented cans in dry</li> </ol> </li> </ul>		e the 446.					
	chili sauce.  b. Raw shell eggs we refrigerator shelf above dressing and other reconstructions.  2. Cleaning and Sanita.  There were opened sour cream, cottage of reach-in refrigerator.  b. A box of cocoa por sugar were stored un room.  c. A scoop was stored laying in the flour.  d. The interior of the refrigerators, and over	ady to eat food.  tation Issues:  ed, undated containers cheese and yogurt in the wder and a container of covered in the dry storated in the flour with its had ice machine, reach-in	in of e f age					
		lids in the kitchen were						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
NI/S2224MDV		NIVO 200 ANADY	B. WING			C	
NVS3224MDX		NVS3224MDX	CTDEET ADD	DESC CITY STA	ATE ZID CODE	03/1	6/2011
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
LAS VEGA	AS RECOVERY CENTER			FFALO DRIVE S, NV 89129			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
M 174	Continued From page	3		M 174			
	a. The door gaskets refrigerator in the kitch		urod				
	c. The ice machine a drain lines were exter sink and did not have	nd three compartments	sink				
	sink and did not have the required air gap to prevent backflow.  d. There were damaged floor tiles in the kitchen.  e. The caulking between the wall and dishmachine was soiled and damaged.  f. The soiled, wet mop was left in the mop bucket by the three compartment sink and numerous brooms were also stored in this area.		hen.				
Severity 2: Scope: 3							
M 177 SS=C	NAC 449.15351 Dieta	•		M 177			
	as a consultant on pla food. At least 4 hours is required. A person the requirements for r	alified person must be canning meals and serving of consultation each mais qualified only if he may be segistration with the tic Registration as a discontinuous and the segistration as a discontinuous and seguents.	ng onth eets				
	Based on record reviet the facility failed to en qualified person cons	of met as evidenced by: ew and interview on 3/1 isure a professional, ulted with the facility at on planning meals and	6/11,				
Severity: 1 Scope: 3							

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NVS3224MDX

STREET ADDRESS, CITY, STATE, ZIP CODE

(X2) MULTIPLE CONSTRUCTION

A. BUILDING
B. WING
C
03/16/2011

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
LAS VEGAS	RECOVERY CENTER	3371 N BUFFALO DRIVE LAS VEGAS, NV 89129					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		